

THE

BOSTON MEDICAL AND SURGICAL JOURNAL.

NEW SERIES.]

THURSDAY, DECEMBER 16, 1889.

[VOL. IV.—No. 24.]

Original Communications.

MEDICAL EDUCATION OF WOMEN.

By EDWARD H. CLARKE, M.D., Professor of Materia Medica in Harvard College.

THE recent occurrences in Philadelphia, by which a medical class in that city have acquired an unenviable notoriety, have brought the subject of the medical education of women more prominently before the community than before. Nothing advances any cause so much as the martyrdom or persecution of its disciples. In this way the Philadelphia medical class have given an unexpected impetus to the cause they opposed. In an address to the graduating medical class of Harvard College, delivered last March, I considered briefly the subject of the medical education of women. In view of the recent occurrences at Philadelphia, these remarks may be of interest to some, who were not in the audience to whom they were addressed. They are presented here as a contribution to the discussion of a subject, which the community will continue to discuss till a satisfactory solution is reached. It is perhaps needless to say that the following views are not given as those of the medical department of Harvard College on this subject. The writer alone is responsible for them. The style of an address to a class is preserved on account of the inconvenience of altering it.

"With regard to another matter, in which you are somewhat personally interested, public opinion is vacillating. I refer to the status of woman in the community. Her claim for admission into the medical profession is only a part of her general claim for admission into every possible avenue of labor. Whatever may be the final decision of this question, it is evident that the light which physiology can throw upon it—the facts which physicians can best supply—will contribute largely to its correct solution.

"I am aware that this is a delicate subject. So much ridicule, sarcasm and false senti-

ment have been thrown about it of late, that it is difficult to speak of the woman question without exciting a smile. But in spite of ridicule, prejudice, sentiment and passion, the question forces itself upon the community. It demands and will have a hearing and an answer. I do not propose to inflict upon you a discussion of woman's sphere. For you may be sure that whatever she can do, she has a right to do, and eventually will do. Everything finds its own place, whether it be a flower or a poem, a race or an individual, a man or a woman. But as in the effort to open for herself a broader way of life, woman just now knocks hardest at the physician's door, it would be alike mean and inexpedient not to give her a courteous hearing and the best answer. Thus can medicine, thus can you and I, aid in the formation of a correct public opinion.

"There are one or two considerations that are important in this connection. The first is that, *a priori*, woman has the same right to every function and opportunity, which our planet offers, that man has. It is idle to talk about this or that being right for man and wrong for woman. Whatever is right for one is right for the other. The real question is not one of right, but of capability or possibility; and this resolves itself into one of organization and development. Just here, comes in the necessity of interrogating physiology. An exact knowledge of woman's organization and possible development, would show both what she can do and what she ought to do. What the possible and coming woman may be, I will not venture to say. This, however, may be safely affirmed, even after giving the fullest credence to Darwin's theory of development, that a woman will never develop into a man, or a man into a woman.

"There is a second consideration, which is a corollary from the preceding one. It is this. If woman has the same right that man has to every sort of knowledge and every sort of work, it follows that she has an equal right with him to the privileges and the responsibilities of the medical profession. This is not only so *a priori* grounds, but there is nothing in the nature

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of Medicine to forbid it. Medicine knows among her votaries no distinction of race, or sex or color. The doors of her temple are open to all worshippers. According to the ancient Pelasgic mythology, Esculapius was surrounded by a cortege of disciples of both sexes, who dispensed his benefits to mortals. This was the earliest symbol of medicine, and is typical of it. Our modern science is no degenerate child of the ancient God, and with outspread arms welcomes all who can do her bidding.

"I say, can do her bidding, for here lies the real question. The point about which public opinion is to crystallize is not whether woman has the right to study and practise medicine, for she has this so clearly that it is absurd to doubt it; nor whether there is anything in medicine itself, that is improper for woman to know or to deal with, for science—knowledge—may ennoble, it can never degrade man, woman, or angel; the point about which the public is in doubt, and needs enlightenment, is simply whether woman's organization will permit her to undertake the toil of the medical profession and successfully compete with men therein. It is not more true that one star differeth from another star in glory, than that man differeth from woman. The glory of man is one; the glory of woman is another. But difference is not inferiority. The sexes, though different, are joined by equal privileges and equal rights. If woman's organization does not adapt her to the practice of medicine, she will never succeed in it. If the reverse is true, no opposition or prejudice, no law, argument or ridicule will prevent her from successfully engaging in it.

Under these circumstances, the course of wisdom for you and for the medical profession is not to oppose the efforts of women in this direction. Let the experiment of trying female physicians be fairly made. Throw no obstacle in the way of a complete experimental solution of the problem. The underlying principle of your profession is to seek for the demonstration of the truth. In fifty years we shall get the answer. Shall I hazard a conjecture as to the answer? It would be this. Guided by the light of physiology, I have no doubt that women can master the science of medicine, as they have done that of astronomy and mathematics, as successfully as men; but that only in exceptional departments will they become successful medical practitioners.

"The admission of females into our medical schools, under the present organization of the latter, involves not only the question

of the medical education of females, but the propriety of teaching the two sexes, at the same time and in the same room, with the same illustrations, human anatomy, human physiology and human pathology. I do not admit that there is anything demoralizing in these studies to either sex. On the contrary, they are ennobling; but it does not follow because they are so, that it will elevate and purify boys and girls, or men and women to study them together. A bath is a necessary, luxurious and purifying process for all, but it does not follow that it is wise for the two sexes to bathe at the same time and in the same tub. A certain amount of juxtaposition of the sexes ennobles both; more than a certain amount degrades both. I will not undertake to argue this point with those who do not instinctively feel and acknowledge its truth. I will only say, that I would not have a son of mine associate with any woman, who felt no impropriety about dissecting the human body with him. I hope to live long enough to see, here in Massachusetts, the ballots falling impartially from male and female hands into all our ballot boxes; so shall liberty and justice be made secure forever; but God forbid that I should ever see men and women aiding each other to display with the scalpel the secrets of the reproductive system; or with crucible and microscope investigating the constituents of the urine; or charmingly discussing together the labyrinthine ways of syphilis.

"Do you ask, then, how women are to obtain the education, by which to prove or disprove their ability to practise the art of medicine? The answer is evident:—Those who desire to have the experiment tried must furnish some of our existing medical schools with the means of giving separate medical instruction, or they must build and endow separate schools for women."

CONSTRUCTION OF THE ŒSOPHAGUS.

By W. A. GILLESPIE, M.D., Louisa Co., Va.

ON Feb. 1st, 1869, I was called to a Mr. R., who had been in California some years ago, where he contracted a disease for which he was profusely salivated by a quack doctor. The result was that ulceration of the posterior fauces caused a cicatricial contraction and stoppage of the posterior nares and a stricture of the upper part of the Œsophagus, seriously interfering with respiration, which was extremely laborious and deficient—the cicatrix pressing on the epiglottis. It also prevented

swallowing anything but liquids. The stricture was gradually increasing, and threatened death by apnoea or starvation. It could be reached by the point of the finger, and admitted the passage tightly of a common-sized bougie. The indications were to remove the stricture, which I attempted by the introduction into it of the bill of a curved (Physick's needle) forceps, and then by forcibly separating the handles to stretch and tear the stricture, which succeeded in some degree, with very little pain or hæmorrhage. I then dilated the stricture by frequent forcible introduction of an instrument A, made by wrapping the end of a common bougie, with a stout wire inside, with strips of cotton cloth covered by smooth leather and securely fastened on, and of a conical shape. This dilated the stricture enough to pass the end of the finger, by which I ascertained that the constricted part was three fourths of an inch wide, callous and firm. Not being satisfied with partial success, I improvised a rude but effective instrument for cutting the stricture, B. On a common bougie, with a stout wire inside to give it a curve and strength, I attached the blade, 2, of a spring lancet projecting through a piece of leather wrapped around and fastened to the bougie, and then, to guard the sound or non-constricted parts from injury by the lancet, I fastened a crooked steel spring at 6, and wrapped it loosely at 5 to let it slip when pressed on by the stricture standing at rest nearly level with the point of the lancet 2, but lying flat on the instrument C at 1, with the lancet freely exposed to cut when pressed on by the stricture. I then measured the distance from the upper front teeth to the stricture, tied a string around the instrument at same distance, and passed the lancet through the stricture, but not deeply. It gave little or no pain, and there was only slight hæmorrhage. After this I used the dilator A rapidly, because its introduction interfered with respiration, and with some force repeatedly. The opening is now from three fourths of an inch to an inch in diameter, admitting the easy introduction of a large stomach-tube.



The patient professes great relief, and says he can now breathe as easily as he ever did in his life, and can swallow solid food—bread, meat, &c., *ad libitum*. In addition, I advised the patient to use the dilator every day himself, to take iodide of potassium in a decoction of sarsaparilla, and to apply daily to the stricture, by means of a small sponge-probang, one grain of extract of belladonna and a portion of tincture of iodine, alternately.

From being greatly afflicted and constantly growing worse for two or three years, the patient is now hopeful of recovery. He is certainly comfortable when compared with his previous condition of torture and despair.

He had been advised to go to some city for surgical aid, upon the ground that there were no surgeons in the country competent to undertake his case.

VIGILANCE TREATED WITH CHLORAL.

By D. F. LINCOLN, M.D., Boston.

A LADY, æt. 40, suffering from nervous prostration, the result of over-fatigue and anxiety. Sleeps only two or three hours, toward morning. Says she went a whole week without sleep, except an hour one night. Opium is said to produce obstinate wakefulness; valerian to have no effect. No perceptible effect was obtained from the use, on different nights, of tinct. lupulinæ ʒij., ext. cannabis (Squibb's) gr. i., ext. hyoscyamin (Allen's) gr. iij., gr. vi. and gr. xii. Finally, a scruple of hydrate of chloral (Markoe's) was given, and the patient slept seven hours; and on the next night enjoyed a tolerable amount of sleep without taking any medicine whatever. As uneasy feelings in the head seemed to follow the use of this agent, the dose was reduced to fifteen grains, and the latter quantity has now been taken on eight evenings, invariably giving a full night's rest of seven or eight hours, and leaving no perceptible unpleasant results of any sort. The relief is immense, and the effect upon the general health is very beneficial, as might be supposed.

PERITONITIS AND ULCERATION OF GALL-BLADDER, FOLLOWING A KICK.

By N. L. FOLSON, M.D., Portsmouth, N. H.

W. F. of this town, a boy 12 years old, perfectly healthy, was kicked by a man on the 12th of June, 1869, and died on the

25th of the same month. The kick on his right side left a mark an inch in diameter on the upper edge of the ilium and an inch above. That mark and surroundings became black and blue, and remained so to his death. After getting away from the man, he laid down under or beside a fence, in great pain for a quarter of an hour, and then went home, an eighth of a mile.

He was restless that night, and had profuse diarrhoea the next morning, with a distressing bearing down at the time of the operations. [This diarrhoea continued, more or less, during his life.] He attended church the next morning, and went to school most of the time. He also played hoop, ball, jumped from fences, wheeled a wheelbarrow with fifty pounds of bone in it, and run and played in various ways with other boys. He complained but little of pain in his side, but laid around the stove and in the sun often; he acted somewhat dumphish a part of the time, looked pale, ate little, and would take no warm drinks as he used to do, but wanted cold water.

On the 25th of June, at ten o'clock in the morning, he had trembling and distress; in a few hours he had vomiting and spasms, which continued from time to time until he died, about twelve o'clock the following night.

The physicians who made the *post-mortem* examination, next day, said there was discoloration of the surface of chest, abdomen and side to a considerable extent; also, that there was a rupture of the gall-bladder and effusion of bile into the cavity of the abdomen; considerable peritonitis; inflammation and softening of the mucous membrane of the stomach.

The man who inflicted the injury was tried for manslaughter, and the jury disagreed. Three were for manslaughter, and nine for assault.

Did the kick kill the boy? Did it rupture the gall-bladder?

No physician attended him during his sickness.

HORN Y TUMOR OF THE EAR.

By J. P. WHITTEMORE, M.D., Haverhill, Mass.

I NOTICED in a former number of your JOURNAL an account of a horn growing upon the eyelid, and the reading of it brought to recollection a circumstance of similar nature which occurred to a townsman and patient of mine, some fifteen or twenty years since, while practising in the town of Chester, N. H. It was this. Mr. B. was a contrac-

tor and builder upon the Ogdensburg railroad at the time of the accident, and previous to my acquaintance with him; and being one day uncomfortably near some of his men who were blasting rocks, a small fragment struck him from the rear and perforated the cartilage of the right ear about three eighths of an inch from the rim near the top. The hæmorrhage, he states, was very profuse and continuous; but the wound soon healed, and the occurrence passed into forgetfulness, until about six months after, when he discovered a hardened excrescence rising upon the rim of the ear, just above the wound. This continued to grow until it attained a length of nearly half an inch and a diameter of about one fourth of an inch, when its size caused it to be troublesome and often much in the way, occasioning tenderness of the soft tissue at its base. About one year, I think, from the time of the accident, I removed the horn by carefully separating the soft from the hardened tissues; when again I had free hæmorrhage from a small artery which seemed to have become the source of supply to the horn. Upon examining the growth, it was found to consist of regular layers or laminae, which resembled in every particular the horns of the lower animals, and had it been removed from such it would have excited no unusual curiosity.

Selected Papers.

SPINA BIFIDA. OPERATION AND REMARKS.

By B. ROEMER, M.D., Kanawha Saloon, W. Va.

I was called in the night of July 20, 1869, to visit Mr. James H——, an operative at one of the salt furnaces in this valley. Found him suffering under cholera morbus consequent on the use of strongly acidulated beer, of which he had partaken at dinner. His wife, having gone nearly to her full term of gestation, was taken in labor a few hours before I arrived, "the waters having broken" suddenly, while endeavoring to wait upon her husband. Satisfying myself of the vertex position of the child's head, I left her in charge of a midwife and gave my attention to the more urgent case. Delivery took place about four hours after the first rupture of the membranes, by which time Mr. H. was sufficiently relieved to allow me to inspect the female infant, at the request of the woman who had taken charge

of it. A watery tumor, globular in form, with a well defined short neck about one inch in diameter, and in size equal to a green walnut inclusive of hull, was found upon the lower lumbar and sacral region. Rudimentary processes were distinctly felt lining each side of the cleft, the lateral arches being only partially developed. I informed the midwife of the nature of this malformation, advised caution in communicating with the parents, and applied a roller sufficiently tight over the tumor to insure moderate pressure and safety from external injury. The color of the coverings was that of the surrounding skin; the child was otherwise well formed, without undue development of head; there was no paralysis of the lower extremities; bladder and bowels acted normally, and the infant took the breast well and at suitable intervals. I saw it again on July 22d; noticed no change save a slight enlargement of the sac, whose envelope was then of a redder tint, and traces of fine bloodvessels more perceptible. While the appetite and natural discharges were regular, I was told that the child was never fully awake, but lay in a semi-comatose condition. The parents doing well, I informed them of the consequences of this affection upon their child. Being themselves poor, and their offspring likely to inherit a similar future, the question of restoration to corporeal independence outweighed the possible loss of their child, and I was requested to do what I thought proper in my endeavor to remedy the malformation.

I will here state that the father is 50 years old, of good muscular strength and build. His wife, a primipara, is 28 years old, and a fair type of feminine muscularity, such as laboring classes usually exhibit; and their respective families are to their knowledge without symptoms of tuberculosis, nor have similar abnormalities been known.

The operation was performed on July 28th. The dimensions of the sac, now of double its original size, were as follows:—

Circumference around neck.....	2 1/2 inches.
" of cyst along median line..	7 1/2 "
" at right angles.....	6 1/2 "
Depth from summit to level of spine.....	2 1/2 "

The covering was of a pale pink color, and its bloodvessels well marked. The instruments, &c., used, were:—Brambilla's trocar (for dropay of the eye), combined with the exploring needle; bistoury; probe; a meningophylax, with convex, but narrow and oblong compressor (see Blasius's aklur-

gische Abbild. Taf. XXI. Fig. 1); needles; adhesive plaster; white wax, and collodion with brush.

Puncturing the sac with the trocar, a sufficient quantity of clear serum* was slowly allowed to escape to collapse the cyst around the cleft for a more careful examination. A small piece of wax was next moulded around the compressor to fit the outlines of the opening, especially at its upper portion, and extravasating with gentle pressure (aided by the blunt probes to reopen from time to time the puncture) as much of the liquid as dilated the sac over and around the cleft, I applied the compressor slightly warmed (to mould the wax still further to the shape of the cavity, and to insinuate itself around the rudimentary lateral arches, which limited each side in shape of small cones) firmly upon it, and gave it in charge of an extempore assistant, whom I had previously instructed. Being satisfied that the compressor controlled fully the communication with the interior spine, I made with the bistoury an incision at a depending point of the sac, thus giving exit to the remaining serum mixed with a little blood from the covering, and formed by a horizontal cut of the envelope two flaps, the upper one sufficiently long and much below the compressor, so as not to interfere with it, and the lower one short to meet it. Two stitches were taken, and four narrow adhesive strips laid across the incision and as near as possible to the compressor, which had not been removed nor relaxed. A firm coat of collodion was then added to close the interstices, and a compress retained by a many-tailed bandage around the body of the child. No further exudation of fluid occurred. The child was quiet throughout the operation, which lasted twenty minutes, and it gave evident signs of appetite, which were gratified at its completion; it took the breast readily. I directed to re-apply collodion wherever it seemed about to peel off.

Aug. 1.—Improving; bowels and bladder act regularly; appetite good; instead of the former comatose condition, the child now has its alternate spells of waking, sleeping, eating, and crying.

Aug. 9.—Removed adhesive plaster and cut one remaining stitch; adhesion perfect and firm. Covered the whole cicatrix with collodion, and re-applied the many-tailed bandage with a compress, a piece of soft

* The quantity of liquid collected amounted to four ounces and three drachms; it was limpid, saline, and not albuminous.

leather one-eighth inch thick, properly secured in a cushion. The child is gaining flesh; motory power over lower extremities unimpaired; measurement of the head, before and since operating, gives as yet no increase in size.

Aug. 29.—The child is doing well; has gained up to this time two pounds in flesh; head unchanged; cicatrix contracting; re-applied a firm coat of collodion and former compress with bandage.

Sept. 17.—The child uninterruptedly improving in strength; weighed to-day fourteen pounds, a gain of four and a half pounds since the operation; motory power perfect, and the appearance differs in nothing from that of other healthy children.

Certain peculiarities of fetal life seem to favor the production of congenital hydrorachis:—

1. The spinal column is proportionately larger in the infant than in the adult; it is symmetric with the head; the primary formative process is more active and centric, and the laws of genesis, because here the most necessary and specifically most required, seem to apply as well to the spine as to the skull.

2. The spinal column is perpendicular to the horizontal diameter of the atlas, and descends uniformly in a straight line; the pressure of the cerebro-spinal fluid and its superstrata is therefore direct and uninterrupted by the friction of subsequent curves. This becomes of greater importance, because:—

3. The pyramidal figure of the spinal column is reversed in the fetus, its apex lying in the lumbar vertebrae. The amount of pressure from the fluid exerted at the apex is represented by the weight of the fluid minus the friction along the walls. Add to this, that the development of the lumbar vertebrae commences usually by five cartilaginous centres, which even at birth are separately movable, and we should, *a priori*, look for a greater frequency of spina bifida in that locality.

The undulatory movement of the fontanelles in an infant is based upon a two-fold cause, an arterial and a respiratory; the former causing the elevation of the covering during or immediately after the systole and a depression in the diastole. Ecker, Burdach, Magendie, and others, found the same ebbing and flowing to exist in the spinal column; and that other observers, Haller and Flourens, have failed to discover it, is probably owing to the selection of animals for experimental purposes which really do not possess this quality (domesti-

cated rabbits). The lungs, however, have a more decided motory power over the brain. As each expiration raises the brain, the cerebro-spinal fluid is propelled upward, and it recedes at the inspiration; the former favoring the propulsion of the arterial blood and retarding the collapse of the venous trunks, while the latter has an opposite result. Ecker has shown that the ultimate removal of the cerebro-spinal fluid conditions a corresponding diminution of the respiratory evolutions of the brain, which is only restored to its former magnitude by closing the wound and allowing the fluid to be reproduced. The venous sinus of the spinal column is, however, capable of greater distention than the vessels of the brain, and a certain volume of fluid finds its way by displacement through the lower portion of the fourth ventricle, cerebro-spinal opening, fourth ventricle proper, aqueduct of Sylvius, third ventricle and foramina of Monro, into the lateral ventricles on each side, by which the overlying brain is elevated.

In the normal relation of the cerebro-spinal fluid with the brain and spinal cord, it secures the surrounding surfaces against friction with neighboring resistive structures, fills the open spaces, and gives way to the various displacements of the contents. The fluid may be said to support the accumulation of venous blood in congestion, inspiration, &c., and is itself supported by the venous blood of the interior vertebral canal. In the reciprocity of this pressure may, perhaps, by future investigations, be found the cause of certain obscure diseases, tetanus, chorea, &c., of which I may speak in a future article.

In the abnormality of a greatly increased volume of fluid in the encephalon, these movements are considerably lessened, of which fact the full and distended fontanelles are the evidence, especially in congenital and internal hydrocephalus, and one of the most important causes of this disease is to be found in the occlusion of the passage of fluid by a membranous gate across the sylvian aqueduct; not because the fluid could, *eo ipso facto*, not be as readily absorbed, but because by a want of retrogressive pressure through this passage to the continuous spinal cord, the restorative activity of the brain is paralyzed and reparation impossible. In hydrorachis, it may be presumed that the movements of the brain are only diminished in a direct proportion with the volume of fluid. Ecker found the spinal undulation *undiminished* after total removal of its fluid, and supposed that the expansive

capacity of the spinal venous sinus must be powerful enough in itself to raise the spinal cord.

The faculty, therefore, of displacing an accumulation of the cerebro-spinal fluid by pressure, as we witness it in spina bifida, is not one peculiar to this affection *per se*; no further morbid condition of the cord and its continuity with the encephalon is necessary for its existence. It constitutes another proof for such a communication. In like manner does the removal of the fluid by puncture diminish or annihilate the support to the bloodvessels, and a failure of counterbalance to any hyperemic status is the consequence.

The comatose condition of the infant with spina bifida is the direct result of pressure.* The experiments of F. Magendie (*loc cit.*) have shown that water of 36°-37° C. (96.8°-98.6° F.) injected through the dura mater produces similar phenomena, sometimes united with irregular muscular action. The volume of pressure also exerts its influence in morbid conditions. Hydrocephalus is usually present when the spinal deficiency is located in the cervical region, less frequently *pari passu* with a lower position. The same analogy by which, according to Morgagni (*de sedibus et causis Morborum*), the absence of a cervical vertebra predisposes to apoplexy is applicable here, for the greater approximation of the heart's impulse to the brain increases also the exponent of pressure of an augmented fluid.

Any sudden impression on the nervous system, not only by disturbances in its characteristics as vital agents, but also by the more mechanical action of a reduced compression (as in the abstracted cerebro-spinal fluid) leads to a constant increase of local sanguine force, and we meet it in the sudden death in childhood from hasty alteration of posture after spasmodic disorders (or disorders of spasmodic tendency), owing to an impaired respiratory process. As adjunct causes, we notice that in infancy the bloodvessels of the brain and spinal column are more liable to give way under pressure without being ruptured, and that, consequently, by the greater fluctuation of the unossified skull the relative quantity of blood can be permanently much increased without giving rise to extravasation. Advanced life gives apoplectic seizures where in childhood we find spasm and hydrocephalus, for the exponents of which we look to the impaction of the nerve centres,

cushioned upon the accumulating blood in its full and fluctuating vessels to the production of a hypostatic hyperemia, under which the animal economy is obliged to succumb. Again, the elimination of the separating medium, the cerebro-spinal fluid, induces nevertheless a congestion of the cerebral veins; certain parts of the brain, &c., approximate each other so that, especially, the pneumogastric nerve is so compressed as to result in pulmonary paralysis or violent epileptic spasm with fatal laryngismus stridulus.*

Passing now to the treatment of spina bifida. We find not only a variety of procedures, but also a seeming indiscriminate as to the best mode to be adopted in certain cases. Some writers favor the Baglivan axiom of "*scire mulla agere pauca*," and advise a course of treatment well suited in a case of an infant of "wealthy or otherwise well to do people." "*To interfere as little as possible with the tumor; if any local medication only a simple discutient lotion, or a defensive and discutient plaster with gentle pressure; abdominal secretions and excretions promoted; a healthy wet nurse under the treatment of a course of iodine* (see *Cope-land's Med. Dictionary*), was perhaps effectually carried out in the case given by Dr. Wm. Pepper (*Amer. Jour. Med. Science*, July, 1867, p. 137), who saw the result of one of the most favorable instances, none of the fibres of the spinal cord entering the sac, not interfered with. The existence, however, of spina bifida in after years, is an exception to the rule, and should not govern the practice and decision of the surgeon.

Repeated puncture of the cyst, with gradual extravasation of the contents, was first practised by Ruysch† and afterward by Abernethy.‡ Abercrombie added gradual pressure, which was more fully carried out by Sir A. Cooper.§

The objections against repeated puncture, with or without systematic pressure, may be summed up as follows:—

1. All cystic collections have a common

* Duges reports a case of spina bifida in *Revue Medicale*, April, 1823, in which he maintains that such a tumor was ruptured in utero, and closed again *ante natum*. This is possible under the supposition that the encasement of the fetus within the membranes and the pressure of the liquor amnii are sufficient to support the cerebro-spinal fluid and counterbalance its gravitation. The subsequent vertex position of the fetus may also aid in effecting this result. In the case here reported, the intra-uterine motions were strong, as common with most children. The coma supervening after birth may be due to the removal of these causes.

† *Observat. Anatom. Chirurg.*, Observ. 35, 36.

‡ *Surg. and Physiol. Essays*, part I., i. 75.

§ *Medico-Chir. Transact.* (Philad. Ed. Anat. and Dis. of the Breast), pp. 55-63.

* F. Magendie, *Physiologische u. klin. Untersuchungen über die Hirn u. Rückenmarkslässigkeit*, pp. 23-26.

tendency to reproduce an altered fluid of greater drainage and destruction to the system. The non-albuminous contents become albuminous, particles of pus and debris of lymph are seen floating about. The few cases on record belonging here, teach, that after a primary diminution of the sac, the irritation was transplanted to the brain (convulsions, hydrocephalus), and after death a creamy pus occupied the cyst in communication with the theca vertebralis; lymph was found adhering to the arachnoid lining, with general appearances of acute inflammation, &c.

2. The most unfavorable grade of spina bifida, "ulcerated coverings, giving way under the inflammation of the membranes of the cord with the symptoms of spinal meningitis," is invited by repeated perforation. (See Copeland, p. 742.) At each extravasation of the fluid, we induce a hyperæmia of the superior bloodvessels and more or less friction between parts before separated.

These objections are of greater import if the perforation is associated with the injection of iodine, as practised by Velpeau and Brainard. In injecting the cyst we really bring an irritating fluid in direct contact with the nerve centres, and if, to obviate the injurious effects of such a contact, we ligate the base of the sac, we must first determine the probable consequences of

1. The absorption of the injected fluid;

2. The inflammation of the constricted membranes and its approach to the internal arachnoid; and,

3. Should all happen well, where is the guarantee that we may expect a removal of the strangulated cyst with perfect adhesion, rather than the third variety of spina bifida, according to Billard (*Traité des Malad. des Enfants*, &c.), "the skin opened, allowing the effused fluid to escape through an ulcerated perforation," and of which he says that death follows speedily? (Copeland, *loc. cit.*, p. 741.)

Dr. Samuel D. Gross tried the proceeding of B. Bell, tying the base of the sac so as to cut off the further propulsion of the fluid, but unsuccessfully. Dubois uses a steel clamp to compress the cyst and bring about adhesive inflammation. The actual cautery has even been proposed. The proceeding of Dubourg* comprises the removal of a part of the sac at its base so as to form two flaps, the finger of an assistant preventing the escape of the spinal fluid and the

entrance of air. The wound is closed with hare-lip pins and the twisted suture. Recommended by him only when the swelling is moderate and the child's head otherwise good. Beynard* surrounds the base of the tumor with a spring into which a ligature is introduced and ties it up. By a gradual constriction of the ligature, the inner walls of the sac are brought into contact, and after effected union he cuts off the exterior and brings the suppurating edges together with adhesive plaster. Sometimes he punctures the cyst, should the swelling be very tense. Chelius prefers the mode of Beynard to that of Dubourg. Most† speaks of electro-puncture, by which he thinks to obtain adhesive inflammation.

The objects which I had in view in operating for spina bifida, as indicated, were:

1. The selection of favorable cases: non-complication with hydrocephalus, other deformities or multilocular and open cysts. Absence of symptoms that the brain is seriously implicated.

2. Gradual and careful extravasation of the contents without suction upon the spinal canal and descent of its fluid.

3. Prevention of entrance of air.

4. Perfect closure of the wound without the use of irritating means, so that all causes leading to local or continuous inflammatory action may be avoided, and healing by first intention promoted.

5. Subsequent systematic support of the cicatrix until the defective spine is supplied with a firm covering, relying upon the efforts of nature to supply the place of an osseous with a cartilaginous formation, as we see it after trephining the skull.

I adopted the perfect occlusion of the spinal opening by means of a suitably-shaped instrument, as fulfilling the second and third proposition. I found, in my collection, the meningophylax of the most promising shape. To obviate the possible escape of the fluid, because of the irregularity of the cavity, I added white wax to the compressor and softened it before its application, to insure its cast-like entrance. Perhaps future operators may find a hollow rubber cone, or calcined gypsum moulded into the cavity and allowed there to harden, of better service still. The time necessary to give solidity to the cast is so short, that no fears need be had on that account, especially if the composition is properly made. The relative length of the flaps is obvious, in order to avoid moving the compressor,

* Jour. de Med. et de Chir. de Toulouse, Sept., 1839. See also Chelius's System of Surgery, translated by South; vol. iii. p. 190.

• Gazette Med. de Paris, vol. ix. pp. 481, 700.

† Encyclopædie der gesammten Med. und Chirurg. Praxis ii. p. 73.

and the whole operation, even to the cost of collodion, is completed before the meningo-phylax is relaxed. I will further mention, as an advantage for this operation, that the assistance necessary can be rendered by any one having a moderate degree of self-possession and fortitude, and that the after treatment can be intrusted to most nurses. The operation once finished, no essential part of it need to be repeated, nor does the uncertainty in the maintenance of uniform pressure, so much depended upon in puncture followed by a hernial support, leave the success of the operation in hands little qualified to guard it effectually. —*Cincinnati Lancet and Observer.*

GUN-SHOT WOUND OF THE KNEE-JOINT.

By R. H. JOHNSON, M.D., Cincinnati.

G. T. D., aged 25, March, 1864, was shot from behind, through the right knee-joint, with a small pistol-ball, at the moment of passing out and over the threshold of the door of a saloon, the limb being flexed just as the foot was raised to make the stride. The ball, on entering the popliteal space, evidently did not touch either of the three *synovial bursae* beneath the adductor magnus, nor the popliteal artery, nor either of its branches—the anterior and posterior tibial—as not a drop of synovia or arterial blood issued from the wound either at entrance or exit of the ball; the latter wound being a little to the left of the centre of the lower edge of the patella. I at first surmised that the ball might have made the half circuit of the joint, but critical examination failed to find any evidence of it. The ball had passed directly through the joint, and without producing any fracture, as the sequel proved. It must have passed between the two lateral eminences, the tuberosities or spine of the tibia; nor was it deflected from its course by the double head of the gastrocnemius, as they are separated when the limb is flexed. The patella was uninjured.

Treatment and Result.—No mechanical pneumatic occlusion of the wounds was applied, as they soon became dry, and apparently healed by first intention—nature obviating the necessity of art appliances. Enormous enlargement of the joint and limb took place, which was combated successfully with free and repeated application of leeches, cold-water dressing, perfect rest and spare diet.

At one of my visits I was surprised to find an enormous poultice covering the joint
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and part of the limb, which I threw out of the window, and learned that a medical friend of the family had been called in by some one, who had applied the poultice. I refused to have anything further to do with the case if to be interfered with in this way—impressed the importance of avoiding suppuration and consequent exhaustion, and perhaps ankylosis or death, and demanded to know whether I should continue to treat him. By his consent and desire, I continued, and the case went on to a rapid and successful termination. In six weeks he was out on crutches, with daily increasing flexion, resulting in such good use of the limb—the joint—at the end of four months, that he went to Indiana and assisted his father in the harvest field, the joint not in the least ankylosed. I saw him today, October 15, when he informed me that the only trouble he had ever had, and still has occasionally, is a neuralgic twitching pain for a moment or two.

What must have been the result had the poultice treatment been continued, as was too often the case in the late war, it is easy to conceive—ankylosis, exhaustion, suppuration, and perhaps death from pyæmia. I have sad remembrance of the death of a gallant colonel of one of the regiments of the 14th brigade, 2d division, army of the Cumberland, from this *poultice* treatment, on board a steamboat at Shiloh, and when I visited him, remonstrated with him and his attendants, warning them of the result, which was exhaustion, suppuration and death from pyæmia.—*Ibid.*

Reports of Medical Societies.

OBSTETRICAL SOCIETY OF BOSTON. SECRETARY,
DAVID F. LINCOLN, M.D.

OCTOBER 9th, 1869.—The society met at the house of Dr. WELLINGTON, at 7½ P.M. In the absence of the President, the chair was occupied by Dr. MIXON, Vice President.

Dr. WELLINGTON spoke of a case of labor which he saw in consultation. Upon his arrival, he found the uterus contracting with vigor, but apparently without effecting any change in the position of the child. This condition had existed for two hours. The presentation was a natural one, the head had passed the brim of the pelvis, and no obstruction to its progress was apparent. The forceps was applied, and the child delivered without difficulty. Dr. W. thought that such retardation of labor might be due

to the fact of the circular fibres contracting, while the longitudinal ones remained inert.

Dr. LYMAN related a similar case, of which he could offer no explanation except the one just given.

Dr. ABBOT described a case of entire separation of the placenta before birth, with death of the child. The labor was the first natural one after several miscarriages. The fetal heart was heard distinctly, two or three hours before the close of labor. Child born dead. A clot, much larger than the placenta itself, came away directly after the latter. Both placenta and child were small. The maternal surface of the former appeared healthy. There was no hæmorrhage before the birth of the child.

Dr. REYNOLDS reported the conclusion of the case of *dropsy of the amnios*, described at the previous meeting of the Society, as follows* :—

At 9 o'clock in the evening of the 27th of June, patient found herself deluged in bed, and, getting up, filled three basins (one wooden pail completely full) with *liquor amnii*. She appeared at my office, in town, at nine the next morning, and was sent, through the benevolence of the Lying-in Hospital, to one of the public charities.

Labor began at 11 that morning, and at 3 in the afternoon a well-developed child, apparently just dead, was born. The child came footling, under the charge of a medical student, who had never before seen a birth of this kind. He is not sure that he felt pulsation in the cord during labor, but the delay in the delivery of the head was quite enough to account for the unfortunate result.

Labor occurred about three weeks earlier than the expected date. Unfortunately, careful observation as to complete maturity of the child was not made. The important fact that no fetal movements whatever were perceived at any time during the pregnancy, together with the apparent over-development of the uterus at seven months, and the extreme sensitiveness of all parts of the uterine wall, have been previously reported.

Convulsions before Term; High application of Forceps; Hand caught between Forehead and end of second Blade of Forceps; Extraction of an immature Head thereby rendered very difficult. Reported by Dr. REYNOLDS.

M. H., æt. 30. Seven years married. Had two preceding miscarriages in early

months. Is now reported eight months pregnant.

On the 24th of August, 1869, at 7½ in the morning, had a severe convulsion. (It was intimated that there had been a violent quarrel just before, perhaps blows.) The convulsions recurred frequently during the day, without return of consciousness. Anæsthetics were not employed. There was no evidence of uterine action.

I saw her at 4 o'clock. There were now some signs of uterine effort. The os was of the size of a quarter-dollar piece, not rigid; head very high; position apparently occiput to left acetabulum; sutures were felt to be freely open; membranes still entire.

She was put under full surgical etherization, long continued. At about 6 o'clock, when the ether had been for a time suspended, there was a slight return of the convulsions, but no other recurrence. The fetal heart seemed to be still beating feebly.

The os dilated well and promptly under the use of Barnes's water bags. At fifteen minutes after six I ruptured the membranes, the head still remaining very high. Fifteen minutes later, at the earliest practicable moment, I applied the long forceps of Dubois. The introduction of the second blade was attended with an amount of resistance which it seemed very hard to explain, and only after that blade had been twice withdrawn, to be cautiously re-applied. To my surprise the extraction, which from the imperfect ossification of the head might have been expected to prove very easy, was extremely slow and difficult. The child, a male, apparently eight months advanced, still, was born with one hand and wrist caught between the forceps and the head. There was, over the right frontal bone, a marked depression of about an inch in length, with irregular edges, as if indented by the pressure of wrist and hand. It is scarcely necessary to point out how inevitably, under such a state of things, the flexed and fixed elbow of the included arm would increase the fetal diameter, and thus resist efforts to extract.

The placenta, which was exceptionally small, was quickly delivered. The uterus contracted well and there was a fair pulse. The patient did not, however, have any return of consciousness, and died in the evening.

Such a history forcibly illustrates the importance of the classical rule, that the free hand of the accoucheur ought invariably to precede the blade which he is introducing. In a case like the one just reported,

* See p. 171 of this Journal, Oct. 7th, 1869.

the very high position of the head, the small amount of dilatation obtained (just enough to permit the forceps), and the urgent necessity for prompt delivery, present perhaps the maximum of difficulties in the exact application of the precept.

Dr. AYER mentioned a similar case. Labor natural to the end of first stage; dangerous faintness then came on; ergot was given, and the child was born in somewhat over an hour, dead. The placenta was found floating, with many small clots on the maternal surface.

Dr. HOMANS described a case of congenital purpura. The child was born with a few hemorrhagic spots on its right wrist; similar spots appeared in rapid succession on different parts of the body, bleeding to a moderate extent took place from the mouth and umbilicus, and on the third day the child died, having constantly refused to take the breast. The placenta was in a state of fatty degeneration. The mother was in perfect health, but her only previous labor had been at the seventh month, with a dead child. The husband had had what he thought was syphilis, nine years previously, but without any manifest secondary symptoms. Dr. H. wished to inquire whether there was any known connection between syphilis and purpura.

Dr. MINOR observed that umbilical hemorrhage often occurred in children of perfectly healthy parents.

Dr. AYER cited the instance of a patient, of whose first seven labors six were miscarriages, usually from the sixth to the eighth month. At the ninth labor she bore a living, healthy child. At the eighth the child was well-formed and healthy, but still-born; the circulation in the cord was almost cut off by the smallness of the vessels, owing to hypertrophy of the mucous tissue. The placenta had always looked healthy. The father has had syphilis, but the mother not.

Dr. CORNINE inquired how often, in the experience of the members of this Society, occurred a necessity to use forceps for extricating the head after the delivery of the trunk. He quite recently had his first case of the kind. The patient was 36 years old; with her first child. The labor commenced about noon; he saw her at 8, P.M. The os uteri was considerably dilated, and dilatable; the soft parts lax. The liquor amnii had passed off gradually in the course of the afternoon. The breech presented with back to pubes. The pains were regular, strong, and forcing; yet the child advanced slowly, being evidently delayed by its own

size, and the smallness and firmness of the mother's pelvis. At 2, A.M., the labor progressing very slowly and beginning to tell upon the patient, a blunt hook was passed into the child's groin, and its advance aided in this manner. Nevertheless the body passed the pelvic bones with unusual slowness and difficulty, compressing the cord, which when first reached was pulseless. After the delivery of the trunk the head lodged, with face on the sacrum—the bones of the coccyx firm and unyielding. The chin was brought down without effect; and all manual attempts to extricate the head by changing its position and traction proved unavailing. The body was therefore held forwards and upwards by an assistant, and the forceps applied. The labor was thus terminated not without considerable difficulty. The perineum was not injured. The child was lost. Its weight was eight pounds. The patient convalesced rapidly, and without drawback of any kind.

The chairman, Dr. MINOR, and others, answered that they had never used the forceps in similar circumstances.

Dr. AYER related a case of shoulder presentation, in which he turned by the feet, and thus delivered all of the child except its head, for which the forceps was required.

Dr. PARKS quoted Pajot's caution against hasty traction, by which the occipito-mental diameter might be brought to a right angle with the axis of the pelvis.

Dr. ABBOT described a case of expulsion of an ovum with the hydatidiform degeneration. Hemorrhage was almost constant during four and a half months following conception; and was much more abundant upon lying down. At the end of this period the uterus was artificially induced to contract. The ovum was of the size of an ordinary six-weeks' ovum.

In answer to a question from Dr. LYMAN, Dr. REYNOLDS said that with most nipples he thought the best way of "drawing the breast was to use Thier's pump; called the "téterelle Thier."

Dr. ABBOT thought that a most important point in such procedures was to fit the nipple.

Dr. PUTNAM said that an instrument which alternately produced a vacuum and relaxed the nipple, was very successful.

Dr. LYMAN described the manner in which the child's tongue "strips" the nipple between its tongue and upper jaw, as a milkster strips the cow's udder with his fingers. He had observed the operation in the mouth of an infant with hare-lip. He also related the case of a woman whose nipple was so

poorly developed as to be apparently on a level with the breast. After confinement the breast could not be evacuated; the consequence of which was an excessively troublesome abscess. In her next pregnancy the plan was adopted of breaking off the neck of an ordinary wine-bottle (with smooth lips), and binding it on to the breast in such a manner that the circular rim of glass pressed upon the areola around the base of the nipple. This was done for ten days preceding confinement, and the result was most satisfactory. Not only was a deep circular depression made around the nipple, but the latter became more elevated; and the success of the experiment was established by the ease with which the child when born accomplished the act of sucking.

Dr. WELLINGTON read the following paper.

June 25th, 1869. Mrs. E. G. S., æt. 28. Has an infant ten weeks old. Milk abundant, but, from birth, the child has vomited immediately after being nursed, and has apparently thrown up a large part of what it had taken. Latterly this vomiting has grown worse, and the child, who had never gained much, is losing what little it had gained. This is Mrs. S.'s fourth child. She has nursed all her children; the next older is 4½ years old.

Advised a discontinuance of nursing for a few days, as an experiment, and the feeding of the child on cow's milk.

The infant was nursed at noon of June 25th, and then put upon the bottle. The next two days the mother's breasts were drawn with a breast-pipe. The milk continued abundant; on the 27th inst., nearly a tumblerful was drawn at once.

About midnight of the 27th of June, Mrs. S. felt a severe pain in left arm and leg. The leg became painful as high as the knee, and felt stiff. At times the sensation was that of the limb when "asleep." To her surprise, the milk had entirely disappeared.

During the following day (28th), there was nausea, and the uncomfortable sensations in left arm and leg continued. On the afternoon of that day, an eruption of dark-red spots, about an inch in diameter, appeared all over the body, but more copiously on the left arm and leg than elsewhere, not extending, however, below the knees. In some places the spots ran together; in others they were distinct, and an inch or more apart. The eruption was accompanied with considerable fever; while it was out, the pain in the limbs, nausea, &c., subsided. After three hours the eruption suddenly disappeared; this was fol-

lowed by faintness and nausea, lasting till midnight.

The next day (29th), Mrs. S. felt better, but still had pain in limbs and some nausea.

June 30th.—In forenoon had chills and fever, pain in left leg and arm, and shooting pains through stomach, with nausea and vomiting. At 4, P.M., the milk returned "with a rush," and the various pains left.

July 1st.—Felt sick, as when milk is coming after confinement.

2d.—Some headache and nausea; pain in arm and leg gone; milk abundant.

Since this last date, the breast-milk has continued abundant. The bad feelings of the mother, connected with the sudden departure of the milk, and its equally sudden return, soon disappeared. The child ceased its vomiting after commencing the use of cow's milk, and did not resume it upon leaving the artificial food, and entering upon the second edition of the *lac humanum*. It has thrived well, has passed safely through a severe attack of whooping cough, and has survived partial poisoning from an overdose of opium.

The noticeable things in this case are:—

1st, The sudden disappearance of the milk, and the return of the breasts to their natural condition after nursing had been intermitted for two days.

2d, The symptoms following this disappearance of the milk, viz.—the severe pain in the left arm and leg; the faintness and nausea; the cutaneous eruption accompanied by fever.

3d, The return of the milk on the third day, after premonitory symptoms.

4th, Its improved quality on its return.

Bibliographical Notices.

A Compend of Materia Medica and Therapeutics for the Use of Students. By JOHN C. RILEY, A.M., M.D. Philadelphia: J. B. Lippincot & Co. 1869. Pp. 370.

This work, as the preface states, is not designed to be a full exposition of the subject, but a comprehensive syllabus, embracing outline descriptions of the articles and subjects named which the student may complete in the lecture room or by reference to the United States Dispensatory, or to the more extended text-books on the subject. It may serve as a guide to the beginner, pointing out the leading facts and

principles he is to study, while it may refresh the memory of the more advanced student or the practitioner of medicine. The classification adopted is that usually pursued in the lecture room, and the description of the medicines and the formula for the official preparations are principally compiled from the United States Dispensatory and Pereira's *Materia Medica*. The book is well printed on good paper, but is too bulky for the student's use in the lecture room. If it had been interleaved with blank pages in order that the rough notes of the lecture room might be distributed at leisure to their appropriate sections for future reference, it would be of much greater value to practitioners and students.

A Course of Practical Chemistry; arranged for the Use of Medical Students. By Wm. ODLING, M.B., F.R.S., &c. With Illustrations. Philadelphia: Henry C. Lea. Pp. 261.

THE American re-print from the fourth London edition of this valuable handbook of practical chemistry. The new system of atomic weights and formulæ has been employed throughout, and the analytical portion of the work, in so far as regards the description of the methods employed, has been re-arranged. No general changes have been made in the nomenclature.

Medical and Surgical Journal.

BOSTON: THURSDAY, DECEMBER 16, 1869.

FACE PRESENTATIONS IN PARTURITION.

IN a late number of the *New York Medical Journal* is an article by Isaac E. Taylor, M.D., Emeritus Professor of Obstetrics, &c., in Bellevue Hospital Medical College, New York, on the *Spontaneous and Artificial Delivery of the Child in Face Presentations, with the Chin posteriorly*.

Dr. Taylor concludes his remarks with the following propositions:—

"1. That mento-posterior positions of the face are the most frequent; that spontaneous delivery may be accomplished as easily, readily, and safely, as in mento-anterior cases; that rotation of the chin forward to the pubes can occur, even though the face has descended into the excavation, and sometimes just as the child appears to be born.

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"2. That these cases may be delivered spontaneously—by cephalic version in the pelvis, and by the passing also of the child's face over the perineum, the chin appearing first. In other cases, the occiput may emerge from under the pubes first.

"That if rotation of the chin anteriorly cannot be accomplished naturally, nor by artificial resources, I propose first the *division of the perineum laterally*, on whichever side the chin presents, and before craniotomy is performed.

"That should the natural powers of the uterus not effect delivery even after division of the perineum, the application of the long *straight* forceps should be resorted to in preference to the curved, and the direction of the traction should be made directly downward and backward."

Although Dr. Taylor's first proposition would indicate the contrary, we have been taught that the *position* of the head in face presentations is a matter of great importance; and some of the citations he has made show that he has eminent authorities against his view. The general tenor, also, of his remarks and the bold treatment he recommends in his paper are not quite in harmony with the statement above "that spontaneous delivery may be accomplished as readily and safely as in mento-anterior cases."

Let us start with a clear apprehension of the point in discussion. We are wont to say that in vertex presentations the most favorable *position* of the head for delivery is with the occiput forwards; and that when that part of the fetal cranium is directed backwards its descent is less easy. The principal reason is obvious: the shape of the child's head, in the first case, corresponds, in its passage through the pelvis, with the curve of Carus; in the second case it does not. In face presentations, however, the situation is changed.

In face presentation we have the same variety of positions as when the vertex is the presenting part. But, it is usually taught that when, in face presentation, the occiput is *anterior*, the obstacles to delivery are much greater than when it is directed backwards. Let us follow some of Dr. Taylor's quotations:—

"Cazeaux has remarked that 'they [mento-posterior cases] are at term one of the most difficult in the obstetric art to treat.'

"Chailly: 'This is impossible to be delivered unless the face should change its position anteriorly.'

"Hodge: 'In truth the child must surely perish, and craniotomy be performed if the child is dead.'

"Churchill: 'The older writers describe the head as emerging from the lower outlet, in face presentations, with the chin posteriorly. A moment's consideration will show that this is an impossibility mechanically.'

"Capuron and Mesnard have endeavored to prove on geometrical principles that delivery by the face in any position is impossible without artificial aid.

"Velpau, who entertains favorable views respecting the internal mechanism of the face in the pelvis, says:—'The posterior position of the face: I consider it impossible for the chin, which must always appear first at the vulva, to descend in this attitude as far as the anterior edge of the perineum, unless, as Desormaux remarks, the fœtus be an abortion, for the breast would then be entirely within the pelvis at the same time as the head.'

Dr. Taylor adds:—

"I have quoted from these various authors the views which they entertain on this important subject. To assert with those to whom Naegele refers, that the mento-posterior positions are common with the child born with the chin posteriorly, would be very wide of the fact, and would claim a denial from almost all obstetricians at the present day."

We well remember that Pajot, who, as it was understood, reflected accurately the views of Dubois, used some years ago to instruct his private classes that the deviation in question was of the most serious nature.

Cazeaux states that face presentations occur in the proportion of one in 250 to 300 labors. Dr. Taylor mentions his experience with such presentations thus:—

"The positions I have usually found are:

1. The mento-posterior position, with the chin to the right sacro-iliac synchondrosis.
2. The chin anteriorly to the left acetabulum, the reverse of the first. There were twenty-seven cases of the first, fifteen of the second, and two transverse—forty-four cases in all. In one case there were twins, both face presentations.

"The child therefore presents itself in the oblique position in the superior strait, passes down obliquely into the cavity of

the pelvis, and is born, most generally, in the oblique diameter at the ostium vaginae; for, out of one hundred and twenty-five cases of cranial presentations, which I have marked by nitrate of silver on the vertex to test the obliquity of the child when born, one hundred and five were oblique, the rest antero-posterior; and this is the view entertained by Naegele of the oblique position of the head, and assented to by others. The face follows the same law. Lachapelle, Tyler Smith and Chailly admit the greater frequency of the mento-posterior positions."

We will glance, now, at the why and wherefore of the alleged difference in favor of the mento-pubic position in face presentation. We have mentioned that in vertex presentation the mento-pubic position—that in which the occiput is directed posteriorly—is disadvantageous, because in that case the shape of the foetal head is ill-adapted to the passage through which it has to be expelled. This position is undoubtedly disadvantageous also in face presentation for the same reason. But, this difficulty is far from insurmountable, in that the head being compressible is capable of being moulded into such form as to allow of its descent. And the mento-pubic position has this great advantage in face presentation, that as the face sweeps the sacrum, and makes the curve of Carus, the head becomes more and more flexed and disentangled from the foetal body, by which it is followed, and not accompanied. In other words, the chin may take a more or less fixed stand at the pubis while the face and occiput sweep the sacrum before the body fairly enters the pelvis.

On the other hand, let the occiput, directed forward, be detained at the brim, while the chin is forced into the hollow of the sacrum, and the shoulders are arrested at the brim, the head being extended till the occiput approaches the foetal spine. Now as the head and shoulders can hardly pass the upper strait together, there is here an arrest of the delivery—a bad form of face presentation. Each uterine contraction aggravates the extension—brings occiput and shoulders nearer together, but does not advance the labor.

Dr. Taylor enumerates the different methods of treatment adopted at the present day, as follows:—

"1. Relying upon nature to effect the delivery either by rotation of the chin anteriorly, or by cephalic version in the pelvis changing the face into a natural presentation."

In endorsement of this attitude of the obstetrician, he makes quite extended remarks, from which we take two passages:—

"No one at the present day doubts that face cases are not delivered as naturally as cranial presentations. The only doubt existing in the mind of the profession is, that but very few cases require instrumental or artificial aid, and the opinion of the highest authorities is that mento-posterior positions are not even delivered naturally when the face occupies the excavation, unless nature may effect the rotation of the chin forward. Previously I have shown that the mento-posterior positions of the face are the most frequent, and that the face is oblique. That Nature, in a large proportion of cases, accomplishes her object by rotating the chin anteriorly as readily as she does in the occipito-posterior cases. Cazeaux has asserted that rotation must and does take place before the child's face has reached the floor of the inferior strait, as the neck of the child will not admit of extension low enough in the pelvis, on account of the chest not being able to enter the pelvis with the occiput pressed into the posterior part of the neck or between the shoulders. Tyler Smith considers that rotation is always accomplished, principally when the chin reaches the ischiatic spine. Should rotation not occur at this period of labor when the face reaches the inferior strait, it is deemed an impossibility for the child to be born in that position if the chin points either directly to the sacrum, or obliquely toward one of the sacro-iliac synchondroses. For my own part, I do not consider there is any reason why this class of cases should be so perfectly ignored and considered as impossible or absurd, nor why craniotomy must be resorted to more than in occipito-posterior positions when the child is born with the forehead front and the chin escapes under the pubes, or that these occipito-posterior cases may become face cases just as the child is being born. Boivin has seen one case of this nature, Bedford another, and Moreau claims two cases. I cannot forget a case of this nature where the forehead of the child was pressing upon the pubes and the pelvis of the mother was ample, as the head of the child was resting in the pelvis low down, and before the cervix became dilated. After complete dilatation the fore-

head was pressing under the lower part of the pubes, and it seemed then it would be too late for rotation to occur, as every pain appeared only to wedge the head more perfectly in the excavation, but in a few minutes the child was extruded, complete rotation having taken place with the occiput anteriorly. On the contrary, I have never seen a case where the occiput was posterior, and was delivered in this manner either naturally or artificially, which is a rather unusual experience. Is Nature to be ignored? Certainly not. Who has not seen, and that too very unexpectedly in shoulder presentations, when the shoulder is dipping deep into the pelvis, and it would appear to be utterly impossible for the child to be born unless evisceration were performed, the shoulder become more firmly fixed than ever, and spontaneous evolution taking place, and the child delivered in a few minutes by the breech? My impression is that the views of Naegle and some others have allowed the ordinary measurements of the child's head to square with the usual measurements of the pelvis of the woman. They have thus, in a great degree, set aside the spontaneous delivery of the child in face presentations with the chin posteriorly, and if not rotating round, and the forceps should not succeed, resort to craniotomy." * * *

"The head of the fetus, when born by the vertex, is lengthened in the longest or diagonal diameter, that is, from the chin to the vertex; the vertex is the highest point toward which the roof of the skull forms a gradually inclined plane from the forehead. The diagonal diameter surpasses ordinarily the straight one from forehead to vertex one inch, so that the two diameters form two lines which, when the head is looked at in profile, makes an irregular triangle.

"The occiput of a child born in face presentations appears drawn out or lengthened solely in the direction of the straight diameter; the roof is but slightly arched, being quite flat, and ends in a sharper angle at the forehead. The difference between the straight and diagonal diameters disappears, and the two lines drawn from forehead to vertex, and from chin to vertex, form nearly an isosceles triangle. The head from the arching of the roof and occiput toward the side of the pelvis which it presents to, being straighter than the posterior part of the pelvis which is concave, obstructs the descent, and through protracted uterine contraction the neck is more stretched, and the occiput approaches the back. The skull is flattened and the head has in this manner lost its height, its vertical diameter has de-

creased, and so finds room in the pelvis, and by further uterine contraction passes into the excavation, and the rotation is effected even if the forehead with the anterior fontanelle presents, and, as it were, on the point of being delivered."

By this explanation is shorn of its formidable proportions (as for this conjuncture) the *occipito-mental diameter*, which in the usual shape of the head, and with the ordinary sizes of fetus and pelvis, is too long for brim or outlet, and which, when thus it antagonizes, renders impossible, delivery.

Dr. Taylor subsequently cites two cases of face presentation: mento-posterior position; rotation and delivery by the natural powers. He adds:—

"Braun, in the *Monatschrift für Geburtshülfe*, February, 1861, "On a rare Mechanism in Face Presentation," describes a case in which a mature child, presenting by the face with the chin on the perineum, was delivered by the natural powers in this position. After the birth of the head the back of the child remained directed forward. The child was born dead.

"Dr. Hodge has also referred to a case where the slightest pressure of the finger on the chin, though the head was low down in the pelvis, caused the chin to rotate anteriorly.

"Smellie, in 1748, says:—'I was called to a woman in labor, by a midwife, who told me she found the opening of the child's head below the sacral bones and with the forehead to that point. On examination, I plainly distinguished the face and the chin backwards at the coccyx. In two pains more the face and forehead passed toward the posterior part in the form of a large tumor; the perineum and fundament were greatly lengthened and the vertex and occiput slipped out from under the pubes; the face and forehead turned up from the perineum, and the woman was delivered of a small child.'

"In Braun's case the face was delivered posteriorly over the perineum—that of Smellie from under the pubes, showing that even in this position the child may be born, and therefore delivery is not an impossibility. The vulva may be lengthened immensely—as I have seen in a case of double monster, where the whole back presented, and yet no rupture occurred—fully six and a half inches, as was verified by my friend Dr. Stone. The case of Braun shows that the opinion as laid down by Guillemot proved correct, who says the forehead may continue

to descend and to engage under the arch of the pubes, until the anterior fontanelle appears at the vulva and reaches the border of the perineum, then the process of extension commences.

"The presentation by the face may be converted into one by the vertex. Velpeau remarks that the forehead engages behind the body of the symphysis pubis, while the chin gets below the sacro-vertebral angle. The whole head descends into the excavation beyond the anterior fontanelle from the anterior plane, and the face drags after it the front surface of the neck, and even the upper part of the chest. The occipito-mental diameter, which still presents very nearly the axis of the strait, now begins to perform a *see-saw* movement from above downward and from behind forward. The chin penetrates farther and farther to the bottom of the excavation, though at the same time retained by the thorax, which cannot advance, forces the sagittal suture to slip down behind the pubes, and the forehead to gain the upper part of the inferior strait. The frontal protuberance soon finds a point of resistance on the perineum, and the posterior fontanelle descends in turn, and ultimately appears at the summit of the arch as in occipito-anterior positions. Guillemot attested to the same view. Merriman has also asserted that he has seen two cases, where the chin was placed posteriorly, converted into occipito-anterior natural positions."

"2. Artificial cephalic version before the face has engaged in the superior strait. This comprises both internal version and version by external manipulation."

Of this manœuvre he says:—

"I have attempted it several times, and although I have accomplished the flexion (I speak of primitive cases) while the face is in the superior strait, or still within the cervix, I have never yet seen a case where it retained its flexed position, for it would always return to the normal extended position."

"3. Podalic version.

"4. Artificial rotation—a, by the hand or fingers; b, by the vectis, or by the right-angled blunt hook; c, by the long curved forceps acting as rotators and tractors.

"5. Craniotomy—but before the performance of craniotomy I propose,

"6. Division of the perineum laterally, and afterward the use of the *straight* forceps instead of the curved."

Under the last of these heads he says:—

[When other expedients are not applica-

ble or do not avail] "Are we prepared to say that *craniotomy* alone remains, as this is the *next* procedure recommended to be adopted as the *dernier ressort*? To obviate this unfortunate step, I now pass to the last division of the different points I have presented for consideration, which is the *division* of the perineum laterally on the side to which the chin is directed.

"Previous to entering on this point, I will report some cases showing that, with the chin posteriorly, by the aid of the forceps it is possible for the child to be born without resorting to *craniotomy*, independently of the measure I adopt."

Having quoted three cases of the kind referred to, he proceeds thus:—

"As a substitute for *craniotomy*, therefore, even before the patient has become exhausted, and obeying the imperative law which experience has demonstrated, that every hour after twenty-four hours' delay in the delivery of the mother under adverse symptoms imperils her welfare and tends to sacrifice her life and the life of her child, I consider it imperative to avoid *craniotomy* and endeavor to save the mother much earlier than is usually done. I propose, as I stated above, *division of the perineum laterally*. The operation has, in some instances, been suggested on account of the large size of the child's head, and for a lengthened perineum when laceration is inevitable. It is true the cases demanding this operation were not ordinary, and so are cases of face presentation of the nature under consideration. Michaelis recommended it, and Siebold approved it in vertex presentations with large heads and elongation of the perineum. Ritgen took the same view, but never performed it either in hospital or private practice. Blundell advocated and practised only slight incisions, which were to be made laterally, and done during a pain. Paul Dubois divided the perineum when necessary, directing the oblique incision. Chailly coincides, of course, with the suggestion of M. Dubois. Busch thinks that these incisions should be confined to cases of organic anomalies only. It is admitted that the cases are rare which would demand such an operation, but the rarity of the especial cases under consideration shows the merit of the operation and claims the performance of it, not only for the sake of the child, but also for the mother. The objection of some, that the incision once started may soon be converted into a tear extending even to the anus, is futile. On the contrary, it is to avoid this deplorable

issue of producing vesico- and recto-vaginal fistulae, and the laceration of the whole anus."

Two cases are subsequently related in which delivery was effected by division of the perineum, the child in each case being born dead. The result as to the mothers is not stated.

On the whole, we think Dr. Taylor has succeeded in showing that there is less to fear, even in the worst form of face presentation, than has been frequently supposed; though we must repeat that his first proposition, to our mind, underrates the difficulties of the situation.

LUNATIC ASYLUM.—Mr. Snow, of Ward Eleven, presented the following communication as supplementary to the report made by Mr. S. C. Cobb on a site for a Boston lunatic hospital.

[Copy.]

3 PENNERTON SQUARE, December 7, 1869.

Samuel C. Cobb, Esq. :—

Dear Sir,—I see from your minority report and what you have been doing in the city council that you are opposed to building a new hospital for the insane at Winthrop. I agree with you; and as I have a very deep interest in the management of the insane, and a citizen's interest in the expenditures of the city government, I take the liberty of addressing you upon the subject.

I have lived a part of nearly every year, for twenty years, in Winthrop, not far from the Winthrop farm, so called, on which it is proposed to build the asylum. I have walked, ridden, or driven many times in almost every month of the year along the side of the hill, and have walked over it, and am perfectly familiar with everything about it.

The climate of Winthrop, during the summer months, is very healthy and delightful. But every part of Winthrop is necessarily, from its exposure, very windy. At my house, on ground only thirty feet above the sea level, the winds are always fresh, and in the winter excessively violent. We tried one winter's residence there, and found it, almost constantly, so boisterous, that it was seldom agreeable to take a walk, and the wind often so strong as to make it nearly impossible for a woman to walk at all.

On the top of the hill, on the Winthrop farm, the air is delicious in the hottest days of July and August, and in the soft weather of early autumn, and the prospects are very beautiful. A person visiting it on such a

day, might think it a charming situation. But on almost every day in the winter half of the year, the winds, from whatever quarter, are so furious that a person who has been once there at that season, would not willingly consent to go again till next summer, even for a climb or a look!

The top is absolutely unprotected. The northwest wind dashes upon it, coming over several miles of unbroken water and marsh. The north and northeast winds come upon it over nearly the whole length of Lynn Bay, and the east winds reach it after sweeping over the whole extent of Massachusetts Bay. I never saw a place more unfit to build anything upon but a lighthouse or a beacon; and if it were built upon for human habitation, there are few days in the winter when it would be safe for any but a strong man to walk out. There is scarcely a vestige of a tree there, and it would cost tall fences and high walls and vast trouble and expense to plant trees there.

The site selected for the asylum could be reached only by a long, winding road, which would have to be protected from the winds by lofty walls on each side. Building on that elevated spot would be greatly more expensive than on the plain, as every block of stone, every piece of timber, and the daily supplies for the builders, and for the inhabitants of the house when built, would have to be really lifted upwards to a perpendicular height which would require the expenditure of more force, probably, than would be required to convey those materials from Boston to the foot of the hill. At the foot—and on the lower slopes—of the hill, it would doubtless be easy to find water. But it is so excessively steep on two sides, that it looks as if it would be impossible to get water in any part of the top, and it would have to be pumped up from a distance, at great and perpetual expense. Fountains, gardens, shrubbery, are all wholly out of the question, forever.

No person who had been on the top of that hill in a storm in winter would ever think of building a residence there; and I cannot think of a sane person's thinking of it as a suitable site for any building for human habitation, unless he had visited it only in the pleasantest season of the year, and had utterly forgotten the six or seven months during which it must be as bleak, boisterous and inhospitable as Greenland.

I once took Miss Dix, who is as much interested in, and as well acquainted with, everything which relates to hospitals and asylums for the insane as any person living, to the top of this hill. We talked the whole

matter over then and there; and I know that she entirely agrees with me in everything I have here said.

Earnestly hoping that a more suitable site may be chosen for the contemplated asylum, I am yours, respectfully,

(Signed), GEORGE B. EMERSON.

The communication was laid on the table and ordered to be printed.

Once upon a time a body of officials went to visit the Winthrop farm, to see about the fitness of the place for crazy people. It was a lovely summer's day—the 15th of July or August, we believe. All spoke in praise of the then charming spot—save one who kept silence. Finally that one was appealed to for his opinion by the chairman of the occasion. My opinion, said the hitherto silent one, I am not now prepared to give. But, if you will all meet me here on the fifteenth of January next, I will express it at that time.

ETHER VS. CHLOROFORM. *Mr. Editor,*—Two years ago, while listening to some remarks to his class by Prof. W. W. Greene upon anæsthetics, I made a note of the following, which, in connection with the frequent reports of deaths from chloroform, I should like to see in your JOURNAL.

M. A. C.

Portland, Me., December, 1869.

"No man can hesitate a moment with regard to the comparative safety of ether and chloroform. The simple fact is that chloroform frequently kills, and, so far as we know, ether never does. The published reports of deaths from chloroform in the various medical journals average nearly two a month, while there is not a well-authenticated case of death from ether on record. With a knowledge of this fact, and also knowing that the majority of these cases have occurred in the hands of skilled and cautious men, the fatal result often taking place during the performance of a trivial operation or before it was begun, I could never feel justified in exposing a patient to the risk of chloroform. During the several years in which I used it I had no trouble, except that in a few instances it so depressed the circulation that I was obliged to withhold it; but no surgeon is justified in quoting his own fortunate exemption from accident as a justification for the use of this agent when in the hands of other men of equal skill, caution and experience, patients, who to the most careful scrutiny

present no contra-indication, do every now and then die as if by lightning stroke. With my present convictions upon this subject, if I should lose a patient under chloroform administered upon my own responsibility I should, in my own conscience, be held guilty of murder. As to mixing the two, I can only say that the more chloroform the more danger, the more ether the greater safety; and I do not believe that any patient can withstand the influence of pure ether administered according to the directions I have given you. In army practice the imperative necessity for economy both in time and transportation probably justifies the selection of the less bulky and more prompt although dangerous agent, especially in field practice, but I wish to put you on your guard in this connection. It has been asserted over and over again that the abundant statistics of military surgery, both in Europe and America, fail to show any fatal results from chloroform. I am surprised that these statements should pass unchallenged, for in the Peninsular campaign and during Gen. Grant's operations before Richmond, I saw several instances in which I feel sure that the death of the patient upon or immediately after removal from the operating table was due to chloroform; and although the attending surgeons referred the result to "shock," superadded to previous exhaustion, my own opinion was corroborated by that of other competent observers; and I firmly believe, both from these cases and from the somewhat unwilling admissions of certain army surgeons made to me personally, that a thorough and impartial analysis of statistics would show many fatal results from chloroform in military practice.

"The only condition in which chloroform is safe is that of pain. As intense suffering neutralizes the effect of opium, so do the pangs of parturition or the terrible twinges of a *tic douloureux* balance the depressing influence of this powerful anæsthetic; and in such cases its use to the point of relief, and no further, is safe."

DEATHS FROM CHLOROFORM.

The *British Medical Journal* for October 2d, 1869, contains the following report of a death from chloroform which occurred at the Croydon Hospital Sept. 15th last:—

C. F., a married woman, aged 52, was admitted on August 28th. * * * To cleanse the wound [sloughing in the region of the patella] and stop the unhealthy ulcerative process, it was resolved to apply nitric acid to the wound; and chloroform was admin-

istered for that purpose on Wednesday, September 15th. Dr. Skinner's apparatus was used, and the drop-bottle, which, by inversion, holds about half a drachm. This was replenished three times. Altogether, two drachms of chloroform was the quantity inhaled. From three to four minutes elapsed before the stage of excitement came on, which lasted three minutes longer. There was no third stage of complete insensibility, such as usually occurs, for the proper performance of a surgical operation; but she died instantly, without the slightest warning, immediately after muscular action. Marshall Hall's method, the Silvester method, and galvanism, were severally had recourse to. The last gave some slight hope of benefit, as the arms were raised, and the hands applied to the mouth; and the diaphragm acted twice, with two corresponding acts of inspiration. But this did not continue; and further efforts at resuscitation were, with regret, abandoned.

No *post-mortem* examination was allowed. A boy, aged 12, employed in the Cwm Neol Coal-Works, was injured on August 22d by being knocked down and run over by a coal train. Some weeks after the accident it was, for the first time, found that he had dislocation of the hip. Dr. Davies resolved in attempting reduction. Chloroform was given on a handkerchief, in doses of twenty to thirty drops at a time. The operators had been pulling at the ropes, when it was noticed that the pulse was failing; and the boy immediately died. He had been under the influence of the chloroform about twenty minutes, and two drachms had been given. As far as regards the chloroform, no blame appears to lie with any one concerned in the administration.—*British Medical Journal*, Oct. 16, 1869.

During the year we have recorded in this journal twenty-five cases of death from chloroform. Commentary upon these figures is unnecessary. Remembering the comparatively insignificant number of alleged deaths from the inhalation of ether recorded since its introduction to the present time, and that there is not one of these "which cannot be explained on some other ground equally plausible" (Rep. of Ether Comm. of Bost. Soc. for Med. Improvement; Extracts from *Record*, vol. iv., Supplement, p. 216)—a statement undoubtedly not true as regards chloroform—we must indorse Prof. Stillé's remark (*Mat. Med. and Therap.*, vol. ii. p. 115, 3d ed.) that "the surgeon who employs it [chloroform] assumes a responsibility of life and death for which neither his office nor the moral law afford him any license."—*Medical News and Library*.

Medical Miscellany.

OBITUARY.—Dr. Benjamin F. Heywood, of Worcester, Mass., died suddenly on the 7th instant. Though he enjoyed comfortable health to the time of his decease, he was known to have cardiac disorder. Dr. Heywood was born April 24th, 1792, and was at his death the oldest physician in Worcester, having for the past few years retired from active practice. He graduated at Dartmouth College in 1812, and then attended the medical lectures of Dr. Nathan Smith at Dartmouth and Yale Colleges, taking his medical degree at New Haven in 1816. He was in partnership with the late Dr. John Green for twenty years. In 1865, the fiftieth anniversary of the commencement of his practice was celebrated. Dr. Heywood had been a Censor and a Councillor of the Massachusetts Medical Society. He also succeeded his father, Captain Benjamin Heywood, as a member of the Society of Cincinnati.

NEW APPLICATION TO ULCERATED SURFACES.—A solution of xyloidine and tannin in ether is praised by Dr. Richardson, of London, as an application to uterine ulcerations—so called. Dr. Richardson says this combination rapidly cicatrizes ulcerated or raw surfaces, and that it acts as an antiseptic by reason of the tannin it contains.

DR. RICORD.—This distinguished specialist has received a gratifying mark of imperial favor. Like M. Nélaton he has been made a Senator. He has also lately received from the Emperor, in connection with a cordial letter, thanking him for his attention during his recent illness, a gold snuff-box, ornamented with diamonds, valued at 20,000 francs. The messenger who carried the present took back the answer that the autograph letter would have been prized just as much without the elegantly jewelled envelope.—*Med. Times and Gazette, and Lancet*, Nov. 27, 1869.

DR. PAUL SCHREFF.—The case of this individual, now under sentence of death for the alleged murder of Miss Steinnecke by prussic acid, in Pennsylvania, has excited unusual attention through the country, and is more particularly interesting to the medical profession on account of the main evidence against the prisoner having come from medical experts. A meeting of the physicians of Washington, D. C., was held on Saturday last, at which nearly all were present, and after a full discussion of the subject, resolutions and a memorial were adopted—stating the grounds for belief that the death was a natural one, and soliciting executive clemency in the case.

In Dr. Richardson's lecture, delivered on Tuesday last, he showed that hydrate of chloral produces sleep when administered as an enema as well as when given by the mouth or introduced subcutaneously. He also showed that butyl alcohol and chloride of amyl, when injected under the skin, produce a deep sleep similar to that from chloral.—*Medical Times and Gazette*.

The number of deaths in the city of Providence, R. I., during the month of November, 1869, was 110. Consumption caused 24 deaths, pneumonia 6, typhoid fever 6, and smallpox 3.

ERRATA.—Page 336, 1st column, 6th line, for "greater" read *less*. In 2d paragraph, 2d column, page 319 of our issue of Dec. 2d, instead of "any other man," read *most other men*.

TO CORRESPONDENTS.—Communications accepted:—Abscess of the Liver.

BOOKS AND PAMPHLETS RECEIVED.—A Winter in Florida; or Observations on the Soil, Climate and Products of our Semi-tropical State; with Sketches of the Principal Towns and Cities in Eastern Florida, &c. &c. By Ledyard Bill. Illustrated. Second Edition. New York: Wood & Hollbrook. Pp. 222.—The Physician's Handbook for 1870. By William Elmer, M.D., and Albert D. Elmer, M.D.—Annual Report of the Surgeon-General, U. S. Army. 1869. Pp. 12.—On the Wasting Diseases of Infants and Children. By Eustace Smith, M.D., Lond., Member of the Royal College of Physicians, &c. Philadelphia: Henry C. Lea. Pp. 196.—Reports of the Trustees and Superintendent of the Tennessee Hospital for the Insane, presented to the General Assembly Nov. 17, 1868. Pp. 60.—The History of nine Cases of Ovariotomy. By T. Gaillard Thomas, M.D., New York. From Bellevue and Charity Hospitals. Pp. 24.—Biographical Sketch of the late A. B. Shipman, M.D., of Syracuse, N. Y. Read before the Onondaga Medical Society by H. O. Jewett, M.D., Cortland, N. Y. Pp. 12.

MARRIED.—At East Somerville, 9th inst., Dr. A. A. Howland of Barre, to Miss Emma Lane, of E. S.

DIED.—In Dover, Me., November 20th, Dr. Benjamin Johnson, aged 67 years.

Deaths in nineteen Cities and Towns of Massachusetts for the week ending Dec. 11, 1869.

Cities and towns.	Number of deaths in each place.	Consumption.	Prevalent Diseases.	Typhoid Fever.
Boston . . . 104	17	14	3	0
Charlestown . . 7	1	0	0	0
Worcester . . . 17	4	1	3	0
Lowell . . . 18	4	3	2	0
Milford . . . 1	0	0	0	0
Chelsea . . . 8	2	0	1	0
Cambridge . . 14	2	0	0	0
Salem . . . 11	2	2	1	0
Lawrence . . . 3	0	0	0	0
New Bedford 11	0	0	1	0
Springfield . 6	2	0	2	0
Pittsfield . . 3	1	0	0	0
Gloucester . . 3	0	1	1	0
Fitchburg . . 3	0	0	0	0
Taunton . . . 6	1	0	0	0
Newburyport . 5	1	2	0	0
Somerville . . 2	0	0	0	0
Fall River . . 16	3	0	0	0
Haverhill . . 4	1	0	1	0
	247	40	24	15

New Bedford reports 4 deaths from whooping cough. Boston reports 5 and Lowell 2 deaths from scarlet fever.

GEORGE DERRY, M.D.,
Secretary of State Board of Health.

DEATHS IN BOSTON for the week ending December 11, 104. Males, 50—Females, 54.—Abscess, 1—accident, 3—apoplexy, 1—inflammation of the bowels, 1—congestion of the brain, 1—disease of the brain, 3—inflammation of the brain, 2—bronchitis, 3—burns, 1—cancer, 1—consumption, 17—convulsions, 3—croup, 1—cystitis, 1—debility, 1—diarrhoea, 3—epilepsy, 2—erysipelas, 1—scarlet fever, 5—typhoid fever, 3—disease of the heart, 2—intemperance, 1—disease of the kidneys, 2—disease of the liver, 1—congestion of the lungs, 2—inflammation of the lungs, 14—marasmus, 4—old age, 3—paralysis, 2—peritonitis, 2—premature birth, 1—puerperal disease, 1—suicide, 1—syphilis, 1—tetanus, 1—tumor, 1—ulcers, 1—unknown, 10.

Under 5 years of age, 30—between 5 and 20 years, 6—between 20 and 40 years, 21—between 40 and 60 years, 29—above 60 years, 18. Born in the United States, 55—Ireland, 30—other places, 19.